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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated “In state” will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, or to request provider manuals or fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Restricted Client Authorization

For authorization for emergency services provided for restricted clients, contact the Surveillance/Utilization Review Section:

(406) 444-4167

All other services must be authorized by the client's designated provider.

PASSPORT Provider HelpLine

For any PASSPORT related questions, or to enroll as a PASSPORT provider:

(800) 480-6823

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

PASSPORT Client HelpLine

Clients who have general Medicaid questions may call the Client HelpLine:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information For Providers* manual.

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for the Direct Deposit Manager.

(406) 444-9500

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone

(406) 444-3456 Fax

Send written inquiries to:

DPHHS

Quality Assurance Division

Certification Bureau

2401 Colonial Drive

P.O. Box 202953

Helena, MT 59620-2953

Lab and X-ray

Public Health Lab assistance:

(800) 821-7284 In state

(406) 444-3444 Out of state and Helena

Send written inquiries to:

DPHHS Public Health Lab

1400 Broadway

P.O. Box 6489

Helena, MT 59620

Lab and X-ray (continued)

Claims for multiple x-rays of same type on same day, send to:

DPHHS

Lab & X-ray Services

Health Policy & Services Division

P.O. Box 202951

Helena, MT 59620

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for cosmetic services and durable medical equipment (DME), contact SURS at:

(406) 444-0190 Phone

(406) 444-0778 Fax

Send written inquiries to:

Surveillance/Utilization Review

2401 Colonial Drive

P.O. Box 202953

Helena, MT 59620-2953

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

(800) 770-3084 Phone

(800) 639-8982 Fax

(800) 247-3844 Fax

First Health Services

4300 Cox Road

Glen Allen, VA 23060

***Mountain-Pacific Quality Health
Foundation***

For questions regarding prior authorization for out-of-state hospital services, transplant services, and private duty nursing services:

Phone:

(800) 262-1545 X150 In state

(406) 443-4020 X150 Out of state and
Helena

Fax:

(800) 497-8235 In state

(406) 443-4585 Out of state and Helena

Send written inquiries to:

Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

Key Web Sites	
Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.state.mt.us	Select <i>Human Services</i> for the following information: <ul style="list-style-type: none"> • Medicaid: Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • Senior and Long Term Care: Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • DPHHS: Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal web sites. • Health Policy and Services Division: Children's Health Insurance Plan (CHIP), Medicaid provider information such as manuals, newsletters, fee schedules, and enrollment information.
Provider Information web site www.mtmedicaid.org	<ul style="list-style-type: none"> • Medicaid: Medicaid provider information including provider manuals, fee schedules, notices and replacement pages, forms and frequently asked questions, newsletters, and key contacts. • CHIP: Information on the Children's Health Insurance Plan • Public Health: Disease prevention (immunizations), health and safety, health planning, and laboratory services • Administration: HPSD budgets, staff and program names and phone numbers, program statistics, and systems information. • News: Recent developments
Center for Disease Control and Prevention (CDC) web site www.cdc.gov/nip	Immunization and other health information
Parents Lets Unite for Kids (PLUK) www.pluk.org	This web site gives information on PLUK – an organization designed to provide support, training, and assistance to children with disabilities and their parents.
Division of Payment Management web site www.dpm.psc.gov/downloads	Download the Direct Deposit Sign-up Form, Stand Form 1199A

- Application of skin creams
- Debridement of nails
- Other hygienic or preventive maintenance care

Sterilization (ARM 37.86.104)

Elective Sterilization

Elective sterilizations are sterilizations done for the purpose of becoming sterile. Medicaid covers elective sterilization for men and women when all of the following requirements are met:

1. Client must complete and sign the *Informed Consent to Sterilization* (MA-38) form at least 30 days, but not more than 180 days, prior to the sterilization procedure. This form is the **only** form Medicaid accepts for elective sterilizations (see *Appendix A Forms* for the form and instructions). If this form is not properly completed, payment will be denied.

The 30-day waiting period may be waived for either of the following reasons:

- **Premature Delivery.** The *Informed Consent to Sterilization* must be completed and signed by the client at least 30 days prior to the estimated delivery date and at least 72 hours prior to the sterilization.
 - **Emergency Abdominal Surgery.** The *Informed Consent to Sterilization* form must be completed and signed by the client at least 72 hours prior to the sterilization procedure.
2. Client must be at least 21 years of age when signing the form.
 3. Client must not have been declared *mentally incompetent* (see *Definitions*) by a federal, state or local court, unless the client has been declared competent to specifically consent to sterilization.
 4. Client must not be confined under civil or criminal status in a correctional or rehabilitative facility, including a psychiatric hospital or other correctional facility for the treatment of the mentally ill.

Before performing a sterilization, the following requirements must be met:

- The client must have the opportunity to have questions regarding the sterilization procedure answered to his/her satisfaction.
- The client must be informed of his/her right to withdraw or withhold consent anytime before the sterilization without being subject to retribution or loss of benefits.
- The client must be made aware of available alternatives of birth control and family planning.



All forms required for sterilizations can be copied from *Appendix A Forms*, can be ordered using the *Medicaid Form Order* sheet in the *General Information For Providers* manual, or can be downloaded from the Provider Information Web Site (see *Key Contacts*.)



Medicaid covers hysterectomies only when they are a result of a procedure performed to address another medical problem, not when the primary purpose is to render the client sterile.

- The client must understand the sterilization procedure being considered is irreversible.
- The client must be made aware of the discomforts and risks which may accompany the sterilization procedure being considered.
- The client must be informed of the benefits and advantages of the sterilization procedure.
- The client must know that he/she must have at least 30 days to reconsider his/her decision to be sterilized.
- An interpreter must be present and sign for those clients who are blind, deaf, or do not understand the language to assure the person has been informed.

Informed consent for sterilization may not be obtained under the following circumstances:

- If the client is in labor or childbirth.
- If the client is seeking or obtaining an abortion.
- If the client is under the influence of alcohol or other substance which affects his/her awareness.

Medically Necessary Sterilization

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and ochiectomies. Every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39). See *Appendix A Forms* for the form and instructions.
- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.
 - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

A notation "Not a Sterilization" on a claim is not sufficient to fulfill these certification requirements.

Surgical services

- The fee schedule shows Medicaid policies code by code on global periods, bilateral procedures, assistants at surgery, co-surgeons, and team surgery. These policies are almost always identical to Medicare policies but in cases of discrepancy the Medicaid policy applies.
- Medicaid only covers “assistant at surgery” services when provided by physicians or mid-level practitioners who are Medicaid providers.
- Medicaid does not cover surgical technician services.
- See the *Billing Procedures* chapter regarding the appropriate use of modifiers for surgical services.

Telemedicine services

- Medicaid covers telemedicine services when the consulting provider is enrolled in Medicaid.
- The requesting provider need not be enrolled in Medicaid nor be present during the telemedicine consult.
- Medicaid does not cover network use charges.

Transplants

All Medicaid transplant services must be prior authorized (see the *PASSPORT and Prior Authorization* chapter in this manual). Medicaid covers the following transplant services:

- For clients 21 years or older: only bone marrow, kidney, or cornea transplants.
- For clients less than 21 years old: all transplants that are covered by Medicare that are not considered experimental or investigational.

Weight reduction

- Physicians and mid-level practitioners who counsel and monitor clients on weight reduction programs can be paid for those services. If medical necessity is documented, Medicaid will also cover lab work. Similar services provided by nutritionists are not covered for adults.
- Medicaid does **not** cover the following weight reduction services:
 - Weight reduction plans or programs (e.g., Jenny Craig, Weight Watchers, etc.)
 - Nutritional supplements
 - Dietary supplements
 - Health club memberships
 - Educational services of a nutritionist
 - Gastric bypass

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

Clients who are enrolled in MHSP have limited coverage for physician-related services. See the *Mental Health Services Plan* manual.

For Medicaid clients seeking mental health services, the information in this chapter applies to mental health services just as it does for physical health services.

Children's Health Insurance Plan (CHIP)

The information in this chapter does not apply to CHIP clients. For a CHIP medical manual contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the *Provider Information* web site (see *Key Contacts*).

PASSPORT Tips

- View the client's Medicaid ID card at each visit, or verify eligibility using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's PASSPORT provider, include the PASSPORT provider's PASSPORT approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to PASSPORT and non-PASSPORT clients and services.
- For claims questions, refer to the *Billing Procedures* chapter in this manual, or call Provider Relations (see *Key Contacts*).

Prior Authorization

Some services require prior authorization (PA) before providing them. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule for PA requirements on specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements. For more details on each service listed in the following table, please contact the prior authorization contact listed.
- For a list of prescription drugs that require PA, see the *PA Criteria for Prescription Drugs* table later in this chapter.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted by the Surveillance/Utilization Review Section, providers will receive notification from both the Quality Assurance Division and the Claims Processing Unit. The *Prior Authorization Notice* from the Claims Processing Unit will have a PA number. This PA number must be included in field 23 on the CMS-1500 claim form.

PA Criteria for Specific Services		
Service	PA Contact	Documentation Requirements
<ul style="list-style-type: none"> • All out-of-state hospital care • All transplant services • All in-state and out-of-state rehab services 	<p>Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602</p> <p>Phone: (406) 443-4020 X150 Helena (800) 262-1545 X150 In and out of state</p> <p>Fax: (406) 443-4585 Helena (800) 497-8235 In and out of state</p>	<ul style="list-style-type: none"> • Required information includes: <ul style="list-style-type: none"> • Client's name • Client's Medicaid ID number • State and hospital where client is going • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis. • Emergency out-of-state services must be reported within two business days of admission. For example, a client admitted on Sunday must report admission by Wednesday.
<ul style="list-style-type: none"> • Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation) <p>(For emergency ambulance transport services, providers have 60 days following the service to obtain authorization.)</p>	<p>Mountain-Pacific Quality Health Foundation Medicaid Transportation P.O. Box 6488 Helena, MT 59604</p> <p>Phone: (800) 292-7114</p> <p>Fax: (800) 291-7791</p> <p>E-Mail: ambulance@mpqhf.org</p>	<ul style="list-style-type: none"> • Ambulance providers may call, leave a message, fax, or E-mail requests. • Required information includes: <ul style="list-style-type: none"> • Name of transportation provider • Provider's Medicaid ID Number • Client's name • Client's Medicaid ID number • Point of origin to the point of destination • Date and time of transport • Reason for transport • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.) • Providers must submit the trip report and copy of the charges for review after transport. • For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.
<ul style="list-style-type: none"> • Eye prosthesis • New technology codes (Category III CPT codes) • Other reviews referred by Medicaid program staff 	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953</p> <p>Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> • Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
• Circumcision	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • Circumcision requests are reviewed on a case-by-case basis based on medical necessity when one of the following occurs: <ul style="list-style-type: none"> • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated. • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene • Urinary obstruction • Urinary tract infections
• Dispensing and fitting of contact lenses	Provider Relations P.O. Box 4936 Helena, MT 59604 Phone: (406) 442-1837 Helena and out of state (800) 624-3958 In state	<ul style="list-style-type: none"> • PA required for contact lenses and dispensing fees. • Diagnosis must be one of the following: <ul style="list-style-type: none"> • Keratoconus • Aphakia • Sight cannot be corrected to 20/40 with eyeglasses
• Prescription Drugs (For a list of drugs that require PA, refer to the <i>PA Criteria for Prescription Drugs</i> later in this chapter.)	Drug Prior Authorization Unit Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 Phone: (406) 443-6002 Helena (800) 395-7961 In and out of state Fax: (406) 443-7014 Helena (800) 294-1350 In and out of state	<ul style="list-style-type: none"> • Refer to the <i>PA Criteria for Prescription Drugs</i> table in this chapter for a list of drugs that require PA. • Providers must submit the information requested on the <i>Request for Drug Prior Authorization Form</i> to the Drug Prior Authorization Unit. This form is in <i>Appendix A: Forms</i>. • The prescriber (physician, pharmacy, etc.) may submit requests by mail, telephone, or FAX to the address shown on the <i>PA Criteria for Specific Services</i> table.
• Maxillofacial/Cranial Surgery	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • Surgical services are only covered when done to restore physical function or to correct physical problems resulting from: <ul style="list-style-type: none"> • Motor vehicle accidents • Accidental falls • Sports injuries • Congenital birth defects • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Client's condition • Proposed treatment • Reason treatment is medically necessary • Medicaid does not cover these services for the following: <ul style="list-style-type: none"> • Improvement of appearance or self-esteem (cosmetic) • Dental implants • Orthodontics

PA Criteria for Specific Services (continued)		
Service	PA Contact	Documentation Requirements
• Blepharoplasty	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • Reconstructive blepharoplasty may be covered for the following: <ul style="list-style-type: none"> • Correct visual impairment caused by drooping of the eyelids (ptosis) • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure) • Treat periorbital sequelae of thyroid disease and nerve palsy • Relieve painful symptoms of blepharospasm (uncontrollable blinking). • Documentation must include the following: <ul style="list-style-type: none"> • Surgeon must document indications for surgery • When visual impairment is involved, a reliable source for visual-field charting is recommended • Complete eye evaluation • Pre-operative photographs • Medicaid does not cover cosmetic blepharoplasty
• Botox Myobloc	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • The following are covered: <ul style="list-style-type: none"> • Blepharospasm - Botox (Type A) only • Strabismus - Botox (Type A) only • Cervical dystonia - Botox (Type A) and Myobloc (Type B) • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Client's condition • Proposed treatment • Reason treatment is medically necessary • Botox/Myobloc is not covered for the following: <ul style="list-style-type: none"> • Any cosmetic purposes • Services that are not approved by the FDA
• Excising Excessive Skin and Subcutaneous Tissue	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • Required documentation includes the following: <ul style="list-style-type: none"> • The referring physician and surgeon must document, in the history and physical, the justification for the resection of skin and fat redundancy following massive weight loss. • The duration of symptoms of at least six months and the lack of success of other therapeutic measures • Pre-operative photographs • This procedure is contraindicated for, but not limited to, individuals with the following conditions: <ul style="list-style-type: none"> • Severe cardiovascular disease • Severe coagulation disorders • Pregnancy • Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

Service	PA Contact	Documentation Requirements
• Blepharoplasty	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • Reconstructive blepharoplasty may be covered for the following: <ul style="list-style-type: none"> • Correct visual impairment caused by drooping of the eyelids (ptosis) • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure) • Treat periorbital sequelae of thyroid disease and nerve palsy • Relieve painful symptoms of blepharospasm (uncontrollable blinking). • Documentation must include the following: <ul style="list-style-type: none"> • Surgeon must document indications for surgery • When visual impairment is involved, a reliable source for visual-field charting is recommended • Complete eye evaluation • Pre-operative photographs • Medicaid does not cover cosmetic blepharoplasty
• Botox Myobloc	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • The following are covered: <ul style="list-style-type: none"> • Blepharospasm - Botox (Type A) only • Strabismus - Botox (Type A) only • Cervical dystonia - Botox (Type A) and Myobloc (Type B) • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Client's condition • Proposed treatment • Reason treatment is medically necessary • Botox/Myobloc is not covered for the following: <ul style="list-style-type: none"> • Any cosmetic purposes • Services that are not approved by the FDA
• Excising Excessive Skin and Subcutaneous Tissue	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • Required documentation includes the following: <ul style="list-style-type: none"> • The referring physician and surgeon must document, in the history and physical, the justification for the resection of skin and fat redundancy following massive weight loss. • The duration of symptoms of at least six months and the lack of success of other therapeutic measures • Pre-operative photographs • This procedure is contraindicated for, but not limited to, individuals with the following conditions: <ul style="list-style-type: none"> • Severe cardiovascular disease • Severe coagulation disorders • Pregnancy • Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

PA Criteria for Specific Services (continued)		
Service	PA Contact	Documentation Requirements
• Rhinoplasty Septorhinoplasty	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • The following do not require PA: <ul style="list-style-type: none"> • Septoplasty to repair deviated septum and reduce nasal obstruction • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction • Medicaid covers rhinoplasty in the following circumstances: <ul style="list-style-type: none"> • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger • Following a trauma (e.g. a crushing injury) which displaced nasal structures so that it causes nasal airway obstruction. • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Client's condition • Proposed treatment • Reason treatment is medically necessary • Not covered <ul style="list-style-type: none"> • Cosmetic rhinoplasty done alone or in combination with a septoplasty • Septoplasty to treat snoring
• Temporomandibular Joint (TMJ) Arthroscopy/ Surgery	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • Non-surgical treatment for TMJ disorders must be utilized first to restore comfort, and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case: <ul style="list-style-type: none"> • Fabrication and insertion of an Intra-oral Orthotic • Physical therapy treatments • Adjunctive medication • Stress management • Surgical treatment may be considered when both of the following apply: <ul style="list-style-type: none"> • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery. • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review. • Not covered: <ul style="list-style-type: none"> • Botox injections for the treatment of TMJ is considered experimental. • Orthodontics to alter the bite • Crown and bridge work to balance the bite • Bite (occlusal) adjustments

PA Criteria for Specific Services (continued)		
Service	PA Contact	Documentation Requirements
• Rhinoplasty Septorhinoplasty	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • The following do not require PA: <ul style="list-style-type: none"> • Septoplasty to repair deviated septum and reduce nasal obstruction • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction • Medicaid covers rhinoplasty in the following circumstances: <ul style="list-style-type: none"> • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger • Following a trauma (e.g. a crushing injury) which displaced nasal structures so that it causes nasal airway obstruction. • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Client's condition • Proposed treatment • Reason treatment is medically necessary • Not covered <ul style="list-style-type: none"> • Cosmetic rhinoplasty done alone or in combination with a septoplasty • Septoplasty to treat snoring
• Temporomandibular Joint (TMJ) Arthroscopy/ Surgery	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295 Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state Fax: (406) 444-0778	<ul style="list-style-type: none"> • Non-surgical treatment for TMJ disorders must be utilized first to restore comfort, and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case: <ul style="list-style-type: none"> • Fabrication and insertion of an Intra-oral Orthotic • Physical therapy treatments • Adjunctive medication • Stress management • Surgical treatment may be considered when both of the following apply: <ul style="list-style-type: none"> • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery. • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review. • Not covered: <ul style="list-style-type: none"> • Botox injections for the treatment of TMJ is considered experimental. • Orthodontics to alter the bite • Crown and bridge work to balance the bite • Bite (occlusal) adjustments

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
<ul style="list-style-type: none"> • Dermabrasion/ Abrasion Chemical peel 	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295</p> <p>Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> • Services covered for the following: <ul style="list-style-type: none"> • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined. • The removal of pre-cancerous skin growths (keratoses) • Documentation requirements include a letter from the attending physician documenting: <ul style="list-style-type: none"> • Client's condition • Proposed treatment • Reason treatment is medically necessary • Pre-operative photographs
<ul style="list-style-type: none"> • Positron Emission Tomography (PET) Scans 	<p>Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-295</p> <p>Phone: (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> • PET scans are covered for the following clinical conditions: (For more details on each condition and required documentation, contact the SURS unit.) <ul style="list-style-type: none"> • Solitary pulmonary nodules (SPNs) - characterization • Lung cancer (non small cell) - Diagnosis, staging, restaging • Esophageal cancer - Diagnosis, staging, restaging • Colorectal cancer - Diagnosis, staging, restaging • Lymphoma - Diagnosis, staging, restaging • Melanoma - Diagnosis, staging, restaging. Not covered for evaluating regional nodes • Breast cancer - As an adjunct to standard imaging modalities for staging clients with distant metastasis or restaging clients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated • Head and neck cancers (excluding CNS and thyroid) - Diagnosis, staging, restaging • Myocardial Viability - Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan. • Refractory Seizures - Covered for pre-surgical evaluation only. • Perfusion of the heart using Rubidium 82 tracer (Not DFG-PET) - Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (continued)												
Service	PA Contact	Documentation Requirements										
• Reduction Mammo-plasty	<p>SURS P.O. Box 202953 Helena, MT 59620-2953</p> <p>Phone: (406) 444-0190 Helena and out of state</p> <p>(406) 444-1441 Helena and out of state</p> <p>Fax: (406) 444-0778</p>	<ul style="list-style-type: none"> • Both the Referring physician and the surgeon must submit documentation. • Back pain must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded. • Indications for female client: • Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure. • Female client 16 years or older with a body weight less than 1.2 times the ideal weight. • There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions: <ul style="list-style-type: none"> • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted. • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy. • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back. <p>Documentation in the client's record must indicate and support the following:</p> <ul style="list-style-type: none"> • History of the client's symptoms related to large, pendulous breasts. • The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.). • Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented): <table style="width: 100%; border: none;"> <thead> <tr> <th style="text-align: left; width: 50%;">Height</th> <th style="text-align: left; width: 50%;">Weight of tissue per breast</th> </tr> </thead> <tbody> <tr> <td>less than 5 feet</td> <td>250 grams</td> </tr> <tr> <td>5 feet to 5 feet, 2 inches</td> <td>350 grams</td> </tr> <tr> <td>5 feet, 2 inches to 5 feet, 4 inches</td> <td>450 grams</td> </tr> <tr> <td>greater than 5 feet, 4 inches</td> <td>500 grams</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • Pre-operative photographs of the pectoral girdle showing changes related to macro-mastia. • Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery. • Indications for male client: • If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first. • Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs 	Height	Weight of tissue per breast	less than 5 feet	250 grams	5 feet to 5 feet, 2 inches	350 grams	5 feet, 2 inches to 5 feet, 4 inches	450 grams	greater than 5 feet, 4 inches	500 grams
Height	Weight of tissue per breast											
less than 5 feet	250 grams											
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5 feet, 2 inches to 5 feet, 4 inches	450 grams											
greater than 5 feet, 4 inches	500 grams											

Medicaid PA Criteria for Prescription Drugs	
Drug	Criteria
Non-steroidal Anti-Inflammatory Drugs PA required for all single-source NSAIDS: Ponstel Mobic Naprelan	Trial and failure with at least <u>two</u> multiple-source products must be documented.
Celebrex (celecoxib) Vioxx (rofecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: <ul style="list-style-type: none"> • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD Vioxx 50mg is not recommended for chronic use. Medicaid does not cover Vioxx at this dose for extended periods.
Disease-modifying anti-rheumatic drugs (DMARD) Arava (leflunomide) Enbrel (etanercept) Humira (adalimumab) Kineret (anakinra) Remicade (infliximab)	<ul style="list-style-type: none"> • Diagnosis of rheumatoid arthritis • Rheumatology consult with date and copy of consult included • Failure with or contraindication to methotrexate alone or in combination with sulfasalazine, hydroxychloroquine or Arava, in which case Enbrel, Remicade, or Kineret may be approved either alone or in combination with Arava. • Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel) <ul style="list-style-type: none"> • Enbrel or Remicade whether alone or in combination with methotrexate or Arava may be approved for first-line treatment in clients with moderately to severely active rheumatoid arthritis as evidenced by: <ul style="list-style-type: none"> • > 10 swollen joints • ≥ 12 tender joints • Elevated serum rheumatoid factor levels or erosions on baseline x-rays
Remicade (infliximab)	Diagnosis of: <ul style="list-style-type: none"> • Moderately to severely active Crohn's disease for clients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Ambien (zolpidem) Sonata (zaleplon) Quantity limited to 15 tablets per month.	Trial and failure with at least <u>two</u> multi-source prescription sleep-inducing drugs.
Oxycodone HCL Controlled-Release (OxyContin)	<ul style="list-style-type: none"> • Diagnosis of oncologic pain • Prior authorization is required for all dosing above twice a day and above 320 mg per day.

Medicaid PA Criteria for Prescription Drugs (continued)	
Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Zyvox (linezolid)	Adult clients with vancomycin-resistant enterococcus.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for clients requiring dosages where tab splitting would be inappropriate (i.e., 75 mg, 125 mg).
Tretinoin PA required for clients 26 years and older.	Diagnose of: <ul style="list-style-type: none"> • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Growth hormones	<p>Diagnosis of:</p> <ul style="list-style-type: none"> • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's Syndrome • AIDS-related wasting <p>Children and adolescents must meet the following criteria:</p> <ul style="list-style-type: none"> • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open <p>Growth hormone deficiency in children: Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/milliliter.</p> <p>Growth retardation of chronic renal insufficiency: Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m^2 but pre-renal transplant.</p> <p>Turner's Syndrome: Chromosomal abnormality showing Turner's syndrome.</p> <p>Growth hormone deficiency in adults:</p> <ul style="list-style-type: none"> • Adult Onset: Clients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies, (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • Childhood Onset: Clients who had growth hormone deficient during childhood and now have somatotropin deficiency syndrome (SDS).

Medicaid PA Criteria for Prescription Drugs (continued)	
Drug	Criteria
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.
<p>Gastro-intestinal drugs</p> <p>Includes H-2 antagonists, proton pump inhibitors, Sucralfate, and Cytotec</p> <p>PA required after a 90-consecutive-day course of treatment with proton pump inhibitors.</p> <p>PA required after 30 consecutive days with Sucralfate.</p> <p>Concurrent therapy requires PA.</p> <p>Consecutive alternating regimens of different drugs counted as part of the total 90-day period.</p>	<p>Diagnosis of:</p> <ul style="list-style-type: none"> • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD <p>Other conditions considered on an individual basis.</p> <p>Sucralfate authorized for an initial 30-day concurrent therapy with histamine H2-receptor antagonists and proton pump inhibitors. Concurrent therapy for a period exceeding 30 days considered duplicate therapy and not covered.</p> <p>Concurrent, combination therapy of proton pump inhibitors and histamine H2-receptor antagonists regarded as duplicate therapy and not covered.</p>
<p>Migraine Headache Drugs</p> <p>For monthly quantities greater than 9 tablets:</p> <p>Imitrex (sumatriptan): 4 injections (2 kits) or 6 units of nasal spray</p> <p>Maxalt (rizatriptan)</p> <p>Zomig (zolmitriptan) and Zomig ZMT (zolmitriptan)</p> <p>Migranal (dihydroergotamine): 4 units</p> <p>Axert (almotriptan)</p> <p>Frova (frovatriptan)</p> <p>Relpax (electriptan)</p> <p>Amerge (naratriptan HCl)</p>	<p>Indicated only for treatment of <u>acute</u>, migraine/cluster headache attacks for clients who meet the following criteria:</p> <ul style="list-style-type: none"> • No history of, or signs or symptoms consistent with, ischemic heart disease (angina pectoris, history of MI or documented silent ischemia) or Prinzmetal's angina • No uncontrolled hypertension • No complicated migraine including vertebrobasilar migraine • Not pregnant • No use of ergotamine-containing medication(s) within previous 24-hours • No use of MAOI within previous 2-weeks • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated <p>Only one migraine medication may be prescribed within a month.</p> <p>Concurrent therapy with Stadol will not be covered.</p>

Medicaid PA Criteria for Prescription Drugs (continued)	
Drug	Criteria
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in clients who have experienced a transient ischemic attack or previous ischemic stroke and who have had a recurrent stroke while on aspirin or have failed plavix and have a contraindication to aspirin.
Toradolral (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Stadol (butorphanol) PA required for quantities greater than 3 - 2.5 ml metered dose spray pumps within a one-month period	Indicated for management of pain including post-operative analgesia or acute migraine headache pain for clients who meet the following criteria: <ul style="list-style-type: none"> • No history of hypersensitivity to butorphanol or any components of the product • No history of narcotic dependency or abuse • Not pregnant • No ulcerations of the nasal mucosa • No history of psychological or neurological disorder • No history of head trauma within the previous 7 days • 18 years of age or older • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated.
Smoking Cessation Drugs Nicotine-replacement products Zyban (bupropion)	Authorization given for 4-month course of therapy. Four trials of therapy are allowed.
Trental (pentoxifyline) Pletal (cilostazol) For greater than 12-week supply within a 12-month period.	<ul style="list-style-type: none"> • Diagnosis of <u>intermittent claudication</u> as the result of chronic occlusive arterial disease (COAD) of the lower limbs. Possible causes of COAD include: arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease), arteritis, trauma, congenital arterial narrowing, or other forms of peripheral vascular disease resulting in chronic vascular occlusion in the legs; and • The client has shown clinical improvement in their COAD while on pentoxifylline or cilostazol. • Considered on an individual basis when pentoxifylline or cilostazol is being used as part of a standardized treatment protocol, e.g. bone marrow or oncology treatment protocols.
Viagra (sildenafil) Quantity limited to one (1) tablet per month	<ul style="list-style-type: none"> • Diagnosis of erectile dysfunction. • Males only, 18 years of age or older. • No concomitant organic nitrate therapy.

MHSP PA Criteria for Prescription Drugs	
Drug	Criteria
buspirone (Buspar)	<ul style="list-style-type: none"> • Augmentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least two multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	<ul style="list-style-type: none"> • Diagnosis of bi-polar disorder. • Intolerance, contraindication, or partial response to Lithium, Tegretol, or Depakote.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) lithyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for clients requiring dosages where tablet splitting would be inappropriate (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.

Other Programs

Clients who are enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP) are not enrolled in PASSPORT, so the PASSPORT requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the *Mental Health Services Plan* manual.

For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. The CHIP Dental manual and additional CHIP information are available on the *Provider Information* web site (see *Key Contacts*).

- For services where codes or definitions differ between the CPT-4 and the *American Society of Anesthesiologists' Relative Value Guide*, Medicaid adopts the CPT-4 version.
- Include the total number of minutes in field 24g (*Days or Units*) on the CMS-1500 claim form. Medicaid will convert the number of minutes to the number of time units. Do not include the base units on the CMS-1500 as the claims processing system determines the number of base units (see the *Completing a Claim* chapter in this manual).

Bundled services

Certain services with CPT-4 codes (eg., telephone advice, some pulse oximetry services) are covered by Medicaid but have a fee of zero. This means that the service is typically “bundled” with an office visit or other service. Since the bundled service is covered by Medicaid, providers may not bill the client separately for it.

Cosmetic services

Include the prior authorization number in field 23 (*Prior Authorization Number*) on the CMS-1500 claim form (see the *Completing a Claim* chapter in this manual).

EPSDT Well Child Screens

- Bill for a complete screen using the appropriate evaluation and management (E&M) code for preventive medicine services.
- When billing for partial screens, use the appropriate preventive medicine code with modifier 52 (reduced services).
- See also the EPSDT chapter in this manual.
- For EPSDT overrides on limits and cost sharing, see the *Completing a Claim* chapter in this manual.

Family planning services

Contraceptive supplies and reproductive health items provided free to family planning clinics cannot be billed to Medicaid. When these supplies are not free to the clinic, providers associated with a family planning clinic can bill Medicaid for these items using local code Z0695. These items include:

- | | |
|--------------------|------------------------|
| • Diaphragm | • Oral contraceptive |
| • Foam jelly/cream | • Terazol |
| • Condoms | • Bichloracetic acid |
| • Monistat | • Trichloroacetic acid |
| • Sultrin | • Contraceptive film |

For family planning overrides on cost sharing, see the *Completing a Claim* chapter in this manual.

Immunizations

- Use code Z0805 to bill for the administration of vaccines under the Vaccines for Children (VFC) program.
- There must be a VFC covered code for each unit of service billed with code Z0805. For a list of VFC covered vaccines, contact the Department's immunization program at (406) 444-5580.
- No more than four diagnosis codes are necessary.
- Bill each VFC code with \$0.00 charges.

For example, a provider administers two vaccines: MMR and pneumococcal conjugate. The provider's charge for each vaccine administration is \$5.00.

24.	A	B	C	D	E	F	G	H	I	J	K
	DATE(S) OF SERVICE	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSTD Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	MM DD YY	MM DD YY		CPT/HCPCS MODIFIER							
1	05 13 02		11 0	Z0805	1	10.00	2				
2	05 13 02		11 0	90707	1	0.00	1				
3	05 13 02		11 0	90669	1	0.00	1				

Obstetrical services

If the provider's care includes prenatal (antepartum) and/or postnatal (postpartum) care in addition to the delivery, the appropriate global OB code must be billed. Antepartum care includes all visits until delivery, and there are different codes for specified numbers of visits. There are also different codes for antepartum and postpartum care when only one or the other is provided. Please review your CPT coding book carefully.

Reference lab billing

Under federal regulations, all lab services must be billed to Medicaid by the lab that performed the service. Modifier 90, used to indicate reference lab services, is not covered by Medicaid.

Sterilization

- For elective sterilizations, a completed *Informed Consent to Sterilization* (MA-38) form must be attached to the claim for each provider involved or payment will be denied. This form must be legible, complete, and accurate, and revisions are not accepted. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.
- For medically necessary sterilizations (including hysterectomies), one of the following must be attached to the claim, or payment will be denied:
 - A completed *Medicaid Hysterectomy Acknowledgment* form (MA-39) for each provider submitting a claim. It is the provider's responsibility to obtain a copy of the form from the primary or attending physician.

- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.
 - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

For more information on sterilizations, see the *Covered Services* chapter in this manual.

Surgical services

- Medicaid does not provide additional payment for the “operating room” in a physician's office. Medicaid pays facility expenses only to licensed hospitals and ambulatory surgical centers.
- ***Reporting surgical services:*** Certain surgical procedures must not be reported together, such as:
 - Procedures that are mutually exclusive based on the CPT-4 code description or standard medical practice.
 - When both comprehensive and component procedures are performed, only the comprehensive procedure must be billed.
 - When the CPT-4 manual describes several procedures of increasing complexity, only the code describing the most extensive procedure performed must be reported.

Medicaid edits for some surgical services using Medicare's Correct Coding Initiative (CCI) edits and performs post-payment review on others. See *Coding Resources* earlier in this chapter for more information on CCI.

- ***Assistant at surgery***
 - When billing for an assistant at surgery, refer to the current Medicaid Department fee schedule to see if an assist is allowed for that procedure.
 - If an assistant at surgery does not use the appropriate modifier, then either the assistant's claim or the surgeon's claim (whichever is received later) will be denied as a duplicate service.
 - Physicians must bill assistant at surgery services using the appropriate surgical procedure code and modifier 80, 81, or 82.

- Mid-level practitioners must bill assistant at surgery services under their own provider number using the appropriate surgical procedure code and modifier AS, 80, 81, or 82.
- ***Global surgery periods:*** Global surgery periods are time spans assigned to surgery codes. During these time spans, services related to the surgery may **not** be billed. Group practice members that are of the same specialty must bill Medicaid as if a single practitioner provided all related follow-up services for a client. For example, Dr. Armstrong performs orthopedic surgery on a client. The client comes in for a follow-up exam, and Dr. Armstrong is on vacation. Dr. Armstrong's partner, Dr. Black, performs the follow-up. Dr. Black cannot bill this service to Medicaid, because the service was covered in the global period when Dr. Armstrong billed for the surgery.
 - For major surgeries, this span is 90 days and includes the day prior to the surgery and the following services: post-operative surgery related care and pain management and surgically-related supplies and miscellaneous services.
 - For minor surgeries and endoscopies, the spans are either one day or ten days. They include any surgically-related follow-up care and supplies on the day of surgery, and for a 10-day period after the surgery.
- For a list of global surgery periods by procedure code, please see the current Department fee schedule for your provider type.
- If the CPT-4 manual lists a procedure as including the surgical procedure only (i.e., a "starred" procedure) but Medicaid lists the code with a global period, the Medicaid global period applies. Almost all Medicaid fees are based on Medicare relative value units (RVUs), and the Medicare relative value units were set using global periods even for starred procedures. Montana Medicaid has accepted these RVUs as the basis for its fee schedule.
- In some cases, a physician (or the physician's partner of the same specialty in the same group practice) provides care within a global period that is unrelated to the surgical procedure. In these circumstances, the unrelated service must be billed with the appropriate modifier to indicate it was not related to the surgery.

Telemedicine services

- When performing a telemedicine consult, use the appropriate CPT-4 evaluation and management (E&M) consult code.
- The place of service is the location of the provider providing the telemedicine service.
- Medicaid does not pay for network use or other infrastructure charges.

Transplants

Include the prior authorization number in field 23 (*Prior Authorization Number*) on the CMS-1500 claim form (see the *Completing a Claim* chapter in this manual). All providers must have their own prior authorization number for the services. For details on obtaining prior authorization, see the *PASSPORT and Prior Authorization* chapter in this manual.

Weight reduction

Providers who counsel and monitor clients on weight reduction programs must bill Medicaid using appropriate evaluation and management (E&M) codes.

Submitting a Claim***Paper claims***

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- Accelerated Claims Entry Software (ACES)
- A claims clearinghouse
- By writing your own software using NSF 3 Montana Medicaid specifications

For more information on electronic claims submission, call the Provider Relations number (see *Key Contacts*), and follow the instructions for reaching Electronic Data Interchange (EDI). The information on electronic claims submission will change with the implementation of the electronic transaction standards under the Health Insurance Portability and Accountability Act (HIPAA). Providers will be notified of changes in the *Montana Medicaid Claim Jumper* newsletter.

Claim Inquiries

Contact Provider Relations for questions regarding client eligibility, payments, denials, general claim questions, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A*. Complete the top portion of the form with the provider's name and address. If you are including a copy of the claim, complete side A; if a copy of the claim is not included, complete side B.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct Medicaid provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: <ul style="list-style-type: none"> • View the client's ID card at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the <i>Client Eligibility and Responsibilities</i> chapter of the <i>General Information For Providers</i> manual.
Duplicate claim	<ul style="list-style-type: none"> • Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see <i>Remittance Advices and Adjustments</i> in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.

Common Billing Errors (continued)	
Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. See the <i>PASSPORT and Prior Authorization</i> chapter in this manual.
Prior authorization number is missing	<ul style="list-style-type: none"> • Prior authorization (PA) is required for certain services, and the PA number must be on the claim form (see the <i>PASSPORT and Prior Authorization</i> chapter in this manual). • Mental Health Services Plan (MHSP) claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See the <i>Mental Health Services Plan</i> manual.
TPL on file and no credit amount on claim	<ul style="list-style-type: none"> • If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See <i>Coordination of Benefits</i> in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see <i>Key Contacts</i>) before submitting a claim.
Claim past 365-day filing limit	<ul style="list-style-type: none"> • The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in <i>Key Contacts</i>.
Missing Medicare EOMB	All Medicare crossover claims on CMS-1500 forms must have an Explanation of Medicare Benefits (EOMB) attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, or provider number terminated	<ul style="list-style-type: none"> • Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	<ul style="list-style-type: none"> • Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

These billing procedures also apply to the Mental Health Services Plan (MHSP). These billing procedures do not apply to the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8547.

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT	
I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.	
Signature of Recipient: _____	Date: _____
PHYSICIAN ACKNOWLEDGMENT STATEMENT	
I certify that prior to performing the surgery, I advised _____ <div style="text-align: right;"><small>(Name of Recipient)</small></div> both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.	
Signature of Physician: _____	Date: _____
SIGNATURE OF INTERPRETER (If Required)	
Signature of Interpreter: _____	Date: _____

B. STATEMENT OF PRIOR STERILITY
I certify that _____ <div style="text-align: center;"><small>(Name of Recipient)</small></div> was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____ _____ _____
Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY
I certify that the hysterectomy or other sterility causing procedure performed on _____ <div style="text-align: right;"><small>(Name of Recipient)</small></div> was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____ _____ _____
Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

Instructions for Completing the *Medicaid Hysterectomy Acknowledgment* Form (MA-39)

A. Recipient Acknowledgment Statement

This section is used to document that the client received information about the hysterectomy before it was performed. The client and the physician complete this portion of the form together with an interpreter if applicable. The client must sign and date this form at least 30 days prior to the hysterectomy. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The client or her representative must sign and date the form at least 30 days prior to the procedure.
2. Enter the client's name.
3. The physician must sign and date the form.
4. If interpreter services are used, the interpreter must sign and date the form at least 30 days prior to the procedure.

B. Statement of Prior Sterility

Complete this section if the client was already sterile at the time of her hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy).

1. Enter the client's name.
2. Explain the cause of the client's sterility (e.g., post menopausal, post hysterectomy, etc.).
3. The physician must sign and date this portion of the form.

C. Statement of Life Threatening Emergency

Complete this section in conjunction with Section A in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency.

This section may be substituted for the *Informed Consent to Sterilization* for sterilization procedures (e.g., bilateral salpingo-oophorectomy or orchiectomy) done only for medical reasons. In these cases, replace the word "hysterectomy" with the appropriate procedure name.

1. Enter the client's name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.

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